

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4397

CERTIFICATE OF DEATH

Reg. Dist. No.

04383

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUDLERSVILLE</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>H.</u> Last <u>ANDERSON</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 6, 1875</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM TENANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>HENRY ANDERSON</u>		14. MOTHER'S MAIDEN NAME <u>SARAH TAYLOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>LEMUEL E. ANDERSON, 1727 N. Union St.</u>		Address <u>Wilms, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u> (c) <u>Chronic Myocarditis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 15, 1954</u> to <u>April 23, 1956</u> , that I last saw the deceased alive on <u>April 21, 1956</u> , and that death occurred at <u>1 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>@ 174 ft. 10 in.</u>		DATE SIGNED <u>4/24/56</u>	
PHYSICIAN'S NAME (Type) <u> </u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/23/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SUDLERSVILLE CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward H. Bellows, Millington, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>4/25</u>	24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>

CERTIFICATE OF DEATH

General Hospital
General Hospital
General Hospital
General Hospital

BUREAU V. E.

APR 30 1956

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1.55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04393

4398

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>QUEEN ANNE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>TALBOT</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>SIDGERSVILLE</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>EASTON</u>	<u>20-40-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EVERETT NURSING HOME</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>LOUISE HARDESTY CALLOWAY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>APR. 25 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>APRIL 10, 1858</u>
9. AGE last birthday <u>95</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD HARDESTY</u>		14. MOTHER'S MAIDEN NAME <u>SALLIE ANN WARNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS <u>MRS. DAWSON STAFFORD EASTON</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic myocarditis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>General Arterial Sclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture</u>			
19a. DATE OF OPERATION <u>NO</u>		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>7:00</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 4</u> , 19 <u>55</u> , to <u>April 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 24</u> , 19 <u>56</u> , and that death occurred at <u>5 P.</u> M. from the causes and on the date stated above.			
SIGNATURE <u>@ H. H. H. H. H.</u>		ADDRESS (Street, city, town, state) <u>Spring Hill, Easton, Md.</u>	
DATE SIGNED <u>4/25/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>APR. 30 '56</u>	
NAME OF CEMETERY OR CREMATORY <u>SPRING HILL</u>		LOCATION (City, town, or county) <u>EASTON, MD.</u>	
24. REC'D BY REGISTRAR <u>MAY 3 1956</u>		REGISTRAR'S SIGNATURE <u>Mr. Edgar Lane</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Edgar Lane</u>		ADDRESS <u>Mr. Edgar Lane</u>	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

*George Washington
Gibson
of
New York City
New York*

BUREAU V. S.

MAY 3 1956

RECEIVED

*Office of
Vital Statistics
New York City*

50-100000-2

04395

4399

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 253

Item 13, Film G196 5-1-56 et

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>D.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Chester</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Chester</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle)	(Last) <u>Matthews</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>March 17, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	9. AGE last birthday <u>73</u> yrs. <input type="checkbox"/> If under 1 year <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> If under 24 hrs. <input type="checkbox"/> Hours <input type="checkbox"/> Mfn.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Hester Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Queenie Pulley - Chester, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422-1 Immediate cause	(a) <u>Congestive Heart Failure</u>	<u>See Yrs.</u>
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Arteriosclerotic Cardio-Vascular Disease</u>	<u>? Yrs.</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Inanition

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1955, to Apr. 1, 1956, that I last saw the deceased alive on Apr. 12, 1956, and that death occurred at 9:20 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 18 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04396

4400

CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Price</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Price</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11</u>				d. STREET ADDRESS <u>Price</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C.</u> Last <u>Mullikin</u>				4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>19 56</u>			
5. SEX <u>Fem.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1871</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Cahall</u>				14. MOTHER'S MAIDEN NAME <u>Martha Seney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Mrs. Margaret Kimbles--Price, Md.</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>421.0</u> IMMEDIATE CAUSE (a) <u>Myocardial Regurgitation</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO (b) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>Jan 2</u> , 19 <u>56</u> to <u>4/30</u> , 19 <u>56</u> that I last saw the deceased alive on <u>4/28</u> , 19 <u>56</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>4/30</u>							
ACTUAL SIGNATURE <u>W. Henry Fisher</u> M.D. <u> </u>				PHYSICIAN'S NAME (Type) <u>Centerville Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 2</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Church Hill, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill, Md.</u>				24a. REC'D BY REGISTRAR <u>MAY 1</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 4 1950

RECEIVED

4401

CERTIFICATE OF DEATH

04397

Reg. Dist. No. 254

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Queen Anne</i>		MARYLAND		STATE <i>Oklahoma</i>		COUNTY <i>Creek</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Bradenville</i>		<i>8 weeks</i>		TOWN <i>Sapulpa</i>		<i>73 x .3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<i>11 North Oak</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Lettie</i> (Middle) <i>Reese</i> (Last) <i>Phillips</i>				(Month) <i>April</i> (Day) <i>16</i> (Year) <i>1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>White</i>	<i>Widow</i>	<i>October 27-1873</i>	<i>87</i> yrs.	Months <i>6</i>	Days <i>17</i>	Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<i>Ordnance Nurse Retired</i>			<i>Retired</i>		<i>Highland, Kansas</i>		<i>U.S.A.</i>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>James Jeffers</i>				<i>Marj Williams</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<i>No</i>				<i>No</i>		<i>Grace Phillips Jarney</i> <i>Bradenville, Ind.</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH
176X IMMEDIATE CAUSE (A) <i>Anaplastic malignant melanoma</i>							<i>about 9</i>
ANTECEDENT CAUSE(S) DUE TO (B) <i>labia majora</i>							<i>years</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>metastases general in abdominal cavity severe anemia.</i>							<i>about 6 months</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY?
<i>about 9 years ago</i>		<i>4 years ago August 1952, melanoma Okla.</i>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
				<i>Diagnosis certified by Pathology</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		<i>M.</i>					
22. I hereby certify that I attended the deceased from <i>April 6, 1956</i> , to <i>April 16, 1956</i> , that I last saw the deceased alive on <i>April 15, 1956</i> , and that death occurred at <i>6:04 P.M.</i> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<i>Theodore Sattelmair M.D.</i>				<i>Stevensville, Md.</i>			
DATE SIGNED <i>April 16, 1956</i>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>April 18-1956</i>		<i>Rest Land Memorial Cemetery</i>		<i>Greenville, S.C.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>April 18-1956</i>		<i>John M. Williams</i>		<i>John M. Williams</i>		<i>Easton, Md.</i>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

BUREAU V. 1

APR 20 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

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1. PLACE OF DEATH a. COUNTY		Queen Anne's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE		Md.		b. COUNTY		Queen Anne's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
X Queen Anne - rural				Queen Anne - rural - Nr. Starr											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Near - Starr													
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
						Pott				April 27				1956	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		C				April 27, 1956				Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME		Chantler Pott		14. MOTHER'S MAIDEN NAME		Margaret Jacobs									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spontaneous separation of the</u> DUE TO <u>abnormally implanted placenta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>												INTERVAL BETWEEN ONSET AND DEATH <u>4-6 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour a. g. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I attended the deceased from <u>April 27</u> 19 <u>56</u> , to <u>April 27</u> 19 <u>56</u> , that I last saw the deceased alive on <u>April 27</u> 19 <u>56</u> , and that death occurred at <u>Queen Anne, Md.</u> from the causes and on the date stated above.															
ACTUAL SIGNATURE <u>Kurt Lederer</u>		M.D. <u>Queen Anne, Md.</u>													
PHYSICIAN'S NAME (Type) <u>Dr. Kurt Lederer, Queen Anne, Md.</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>4/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>---</u>		22d. LOCATION (City, town, or county) (State) <u>Queen Anne (Starr), Q. A. Co. Md.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>5/16/56</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Elsie Armstrong</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this artificial has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

100 12.59.200

BUREAU V. S.

MAY 13 1901

RECEIVED
MAY 13 1901

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4402 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04398

Reg. Dist. No. 252

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Prince Md.</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Gladius Mae Shaw</u>				4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 10 - 1932</u>	
9. AGE (In years last birthday) <u>23</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Business College</u>		11. BIRTHPLACE (State or foreign country) <u>Easton Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Gordon H Shaw</u>				14. MOTHER'S MAIDEN NAME <u>E. Corinne McCallister</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>223-23-866</u>		17. INFORMANT Address <u>Gordon Shaw (father) Queenstown P.H.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto accident - Fractured Skull</u> DUE TO <u>+ broken neck</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Two auto in collision</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>12:45</u> a. m. <u>4/15</u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State road</u>		20f. (City or town) (County) (State) <u>Roseville 2.2 Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. Henry Fisher</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>W. Henry Fisher</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>April 17, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christfield Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barton Bros. by J. M. H. Barton Jr.</u>				ADDRESS <u>Centerville, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>5-4-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Elaine Armstrong</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 7 1956

RECEIVED

04400

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

4403

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Q A</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u> LENGTH OF STAY (in this place) <u>10 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u> (Middle) <u>Henry</u> (Last) <u>Thomas</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>29</u> (Year) <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 29, 1897</u> 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Anna Belle Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Henry H. Thomas, Centreville, Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary OcclusionAntecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last(b) Arteriosclerotic Cardio-Vascular Disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 hr.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not While
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov., 1955, to April, 1956 that I last saw the deceased alive on April 16, 1956, and that death occurred at 1:15 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 2 - 1956Helen M. AldridgeJames B. DashiellEaston, Md.4/29/56

MARGIN RESERVE FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. E.

1056 8 19



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4404

CERTIFICATE OF DEATH

Reg. Dist. No. 257

04401

1. PLACE OF DEATH a. COUNTY <u>Green Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Green Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Budlersville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crumpton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Walharen Nursing Home</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>R.</u> Last <u>WALLS</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 28-1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Hessey</u>		14. MOTHER'S MAIDEN NAME <u>Anna Fithian</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1031 Duke Drive</u>	
17. INFORMANT <u>Edgar L. Kane</u>		Address <u>1031 Duke Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> 350x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Paralysis Opitimus</u> DUE TO (c) <u>General Atherosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralysis Opitimus for 12 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>W</u> Day <u>19</u> Year <u>1956</u> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 1955, to <u>April 11</u> , 1956, that I last saw the deceased alive on <u>April 11</u> , 1956, and that death occurred at <u>9:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edgar L. Kane</u> M.D.		DATE SIGNED <u>April 14, 1956</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>April 14</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Crumpton</u>		22d. LOCATION (City, town, or county) (State) <u>Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Kane</u> ADDRESS <u>Church Hill Ind.</u>		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE <u>Edgar L. Kane</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 17

2474

DATE OF DEATH

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BUREAU V. 3

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RECEIVED

APR 11 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4405
CERTIFICATE OF DEATH

04402

Reg. Dist. No. 252

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RED</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Florence E Young</u>				4. DATE OF DEATH Month <u>4</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/22/1988</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Ezikel Dill</u>				14. MOTHER'S MAIDEN NAME <u>Annie Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>William A Young Hallstrom</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Dis.</u> DUE TO (c) <u>Chronic Myocarditis</u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x</u> <u>Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 5, 1956</u> , to <u>April 26, 1956</u> , that I last saw the deceased alive on <u>April 25, 1956</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. H. Stonesifer</u> M.D.				ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u>		DATE SIGNED <u>4/28/56</u>	
PHYSICIAN'S NAME (Type) <u>Chas. H. Stonesifer</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/2/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sandtown</u>		22d. LOCATION (City, town, or county) (State) <u>Hillsboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell</u>				ADDRESS <u>Easton, MD</u>		24a. REC'D BY REGISTRAR DATE <u>5/4/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clive Armstrong</u>			

CENTRAL CASE OF DEATH

James A. ...
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Frank ...
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Domestic ...
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Amie Thomas ...
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William ...
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BUREAU V. S.

MAY 4 1956

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